"Welcome to our practice…"

NAME_____ HOME PHONE_____

ADDRESS_____ CITY_____ ZIP_____

SOCIAL SECURITY#_____ DRIVER SLICENSE_____ BIRTHDATE_____

E-MAIL ADDRESS_____ CELL PHONE_____ OTHER_____

PREFERRED METHOD OF CONTACT OFFICE PHONE HOME PHONE E-MAIL OTHER_____

EMPLOYED BY_____ OCCUPATION_____ BUS. PHONE_____

SPOUSE NAME_____ BIRTHDATE_____

NAME OF FRIEND OR RELATIVE TO NOTIFY IN CASE OF EMERGENCY_____ PHONE_____

NAME_____ HOME PHONE_____

ADDRESS_____ CITY_____ ZIP_____

SOCIAL SECURITY#_____ DRIVERS LICENSE_____ BIRTHDATE_____

EMPLOYED BY_____ OCCUPATION_____ BUS. PHONE_____

DO YOU OR RESPONSIBLE PARTY HAVE DENTAL INSURANCE? YES NO SECONDARY INSURANCE? YES NO

IF SO, NAME OF PATIENT'S INSURED_____ EMPLOYER_____

SOCIAL SECURITY # OF INSURED_____ ID NUMBER_____

INSURANCE COMPANY_____ GROUP NUMBER_____

INS. COMPANY ADDRESS_____

YOUR SPOUSE'S SOCIAL SECURITY #_____ EMPLOYER_____

INSURANCE COMPANY_____ POLICY NUMBER_____

Although financial responsibility rests with each patient,
we will be happy to submit insurance forms on your behalf.

WHO MAY WE THANK FOR REFERRING YOU TO US

NAME_____

CONSENT

This undersigned hereby authorizes Doctor to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs.

_____ _____

Signature of patient (if minor – parent or legal guardian) Date